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State Innovations in EPSDT

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Executive Summary

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is Medicaid's comprehensive and preventive child health program. EPSDT includes not only periodic well-child visits (EPSDT screens), diagnosis, and treatment services, but also supports families' need to access these services. Federal EPSDT law requires each Medicaid agency to cover all services authorized by federal Medicaid law, including services the agency has chosen not to cover for adults. In addition, it requires agencies to cover services needed "to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services."[1]

This broad coverage, combined with the large number of children covered by Medicaid, makes it critical that Medicaid agencies provide efficient and effective access to EPSDT services. Medicaid agencies are responsible for ensuring children get services they need to reach their potential, as well as obtaining value for the money they spend and remaining within budget. With the support of The Commonwealth Fund, the National Academy for State Health Policy worked for two years to support the efforts of state Medicaid staff tasked with improving the access and quality of child health and development EPSDT services to low-income children.

Based on input from an advisory group and state EPSDT staff throughout the project, NASHP identified three state goals for EPSDT improvements, as well as the challenges faced in making progress toward each goal.

1. Providing all children with scheduled EPSDT screenings (well child visits) and other preventive care
2. Providing all children with access to medically necessary diagnostic and treatment services
3. Ensuring the quality of all EPSDT services provided to children

These goals and challenges formed the organizing framework for the project. NASHP worked with EPSDT staff to identify and examine potential and promising strategies for achieving progress toward each goal. An examination of this work revealed eight strategies that one or more states were using to achieve these goals—and that most strategies were intended to achieve more than one of the three goals.

1. **Partnering with others**. Partnerships with others can bring additional experience, expertise and resources to bear on improving EPSDT. Partnerships with public health agencies and provider professional organizations (e.g., the American Academy of Pediatrics or AAP) were frequently reported.
2. **Integrating EPSDT into other initiatives**. Integrating EPSDT into other state initiatives with congruent goals can strengthen both. Initiatives designed to strengthen primary care, such as medical home initiatives, have particular potential for this strategy.
3. **Helping Primary Care Providers implement EPSDT**. Primary care providers are key to effective delivery of EPSDT services but need support to better understand the program and its potential as well as to integrate delivery of EPSDT into standard office practices. Some states are going beyond provider manuals and workshops and providing in-office training or have begun using new communication avenues, including YouTube.
4. **Helping families' secure EPSDT screening services and other preventive care**. Parents have both a responsibility and desire to ensure that their children get needed services, but many need support to understand and access EPSDT services. In addition to informing families about EPSDT, some states are working to ease access in other ways. For example some states are allowing primary care providers to apply fluoride varnish to young children's teeth so that even those who do not see a dentist can gain the benefit.

5. **Supporting care coordination**. Care coordination helps families connect to appropriate services and enables providers to more effectively care for their patients. Some states are providing resources to providers to support care coordination, including: additional funding to pay for staff employed by providers or provider networks; access to care coordination systems the state has established (and pays for) outside the provider's office; and access to Health Information Technology designed to support coordinated care.

6. **Managing Access to Services Not Otherwise Covered by the State Medicaid Program**. In effect, federal EPSDT requirements establish a children's benefit package and medical necessity standard that is broader than most commercial coverage or that available to adults covered by Medicaid. Medicaid agencies need to both cover the services children need and spend state dollars wisely. States have implemented processes to (1) enable children to obtain medically necessary services not otherwise covered by Medicaid and (2) educate providers and families about the extent of coverage and how to obtain these services.

7. **Aligning EPSDT policies with professional standards**. Professional standards are established by leaders in the provider community with consideration of scientific evidence. Aligning EPSDT policies with these standards enables Medicaid to build on this work to ensure quality, enables providers and families to use resources developed to support these initiatives, facilitates partnerships with other organizations by creating similar goals, and eases provider participation by reducing the differences between EPSDT and other coverage. Several Medicaid agencies have worked to align their policies with those communicated through the AAP's *Bright Futures Guidelines for Health Supervision*.

8. **Using Data to Make the Case for Change and Reward Improvement**. Data and measurement are powerful drivers of change because they can be used to show both the need for change and measure progress toward improvement goals. Even a small amount of meaningful data can make a powerful case for change—and even a small reward can incent change. Some Medicaid agencies are using incentives to reward primary care providers or contracted health plans that increase EPSDT screening. Others have used data on performance to negotiate changes to contracts that have resulted in improvements in important areas, such as lead screening.

Introduction

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is Medicaid's comprehensive and preventive child health program. Medicaid agencies must provide EPSDT to children under age 21 who are covered by Medicaid. EPSDT includes not only periodic well-child visits (EPSDT screens), diagnosis, and treatment services but also supports families' need to access these services through methods such as outreach about the program, assistance with scheduling, translation, and case management (care coordination). Although the coverage is broad it is, overall, less expensive than private coverage; the per capita expense of ensuring a low-income child under private insurance between 1996 and 1999 was $1,344, the corresponding figure was $924 under Medicaid – a savings of over 31% per child.[2]

EPSDT approximates a uniform national benefit for children covered by Medicaid. Federal EPSDT law explicitly requires Medicaid agencies to cover EPSDT screens, as well as vision, dental, and hearing services. It also requires each agency to cover all other services authorized by federal Medicaid law, including services the agency has chosen not to cover for adults.[3] In addition, it establishes a national medical necessity standard by requiring agencies to cover services needed "to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services."[4]

Medicaid covers about 1/3 of children ages 1-5 (and about 20 percent of all children[5]). It is therefore critical that Medicaid agencies provide efficient and effective access to EPSDT services. Medicaid agencies are responsible for ensuring children get the services they need to reach their potential as well as obtaining value for the money they spend and remaining within budget. Between 2007 and 2008, state EPSDT performance, as measured by the federal government, improved. As a whole, Medicaid agencies provided both at least one screen to a greater percent of children who should have received one or more screens during the fiscal year (participant ratio) and a greater percent of the number of screens they should have provided based on their individual periodicity schedule as well as the amount of time children were receiving Medicaid (screening ratio). However, there still is clearly room for improvement. In 2008, although the national screening ratio achieved the federal benchmark of 80 percent, the participant ratio fell short of that mark at 63 percent.[6]

This technical report is designed to assist state Medicaid staff who administer the EPSDT program. Information outlined herein provides helpful guidance to staff charged with translating federal EPSDT requirements into their state's Medicaid program policies and operations, coordinating with other state agencies, and ensuring that families, physicians, and other Medicaid providers who serve Medicaid beneficiaries understand the full scope of the preventive, diagnostic, treatment, care coordination, and support services that are covered by the program. This report will also be beneficial to Maternal and Child Health staff, Children's Health Insurance Program staff, federal policy-makers, organizations that work to support Medicaid programs and staff, and EPSDT providers as they work to partner with their state Medicaid agencies to improve the delivery of EPSDT services.

Between 2007 and 2009, the National Academy for State Health Policy (NASHP), with the support of The Commonwealth Fund, worked with the Medicaid staff tasked with administering the EPSDT program (EPSDT coordinators) to support its efforts to improve children's access to health and developmental services as well as the quality of those services. NASHP provided EPSDT coordinators opportunities to share promising practices and consult with experts on topics they identified. An advisory committee consisting mostly of EPSDT coordinators and a representative of the Centers for Medicare and Medicaid Services

(CMS) guided this work and reviewed a draft of this report. Finally, the authors invited comments on the draft from all EPSDT coordinators.

At the start of this project NASHP, in conjunction with the advisory group, identified three major goals that states were seeking to achieve for their EPSDT programs:

1. Providing all children with EPSDT screenings and other preventive care as specified in the state's periodicity schedule;
2. Providing all children with access to the diagnostic and treatment services needed to ameliorate or treat conditions; and
3. Ensuring the quality of all EPSDT services provided to children.

Under the guidance of the advisory group and other EPSDT coordinators, NASHP provided multiple distance and in-person opportunities for coordinators to discuss the barriers to improvement and their strategies for achieving these goals. NASHP staff worked with the EPSDT coordinators to identify the state practices they wished to learn more about and topic experts whose insight they would value. Through these activities, NASHP identified eight innovative strategies that states are using to achieve these goals.

Although the improvement goals are long standing, many of the innovations are either in development or recently implemented. As a result, few states have yet measured the effect of their efforts. However, most were developed by states in consultation with stakeholders and experts and informed by the evidence. For example, state's efforts to improve access to preventive dental care in EPSDT are often in direct response to research that shows how children's oral health is essential to child development and optimal overall health and wellbeing.[7] These states anticipate that their investments will produce improvements—and we anticipate that others can use these ideas to inform their own efforts.

State Goals

Early discussions with the advisory group, as well as a survey of the EPSDT coordinators, revealed three state goals for improving EPSDT: Increasing appropriate screening, improving access to diagnostic and treatment services, and ensuring the quality of care delivered. Together, these goals define an effective EPSDT program and, thus, became the organizing framework for the project. NASHP worked with state EPSDT staff to identify and examine the challenges to achieving these goals, information that would enable Medicaid staff to better address the challenges, and promising strategies that states were developing/using to achieve the goals. Each of these goals is further described below.

Provide Children with Appropriate Preventive Care, Including EPSDT Screenings

Periodic screening visits are the core of EPSDT. Their purpose is to provide the care all children need to stay healthy (e.g., immunizations), to identify any conditions that require further assessment or treatment, and to provide families with information about what to expect as the child grows and how to support that growth. Further, these screening visits are the key service that enables a provider to be a 'medical home' for the child—providing primary care and serving as the child's first and regular point of contact with the health care system. There is strong evidence that a primary care-oriented health system may have benefits for population health, equity in health and cost containment, and reduce ethnic and racial health disparities.[8] Federal legislation provides the basic definition of an EPSDT screen (Section 1905(r) of the Social Security Act or SSA) but all Medicaid agencies establish their own periodicity schedule and further define the content of each visit in consultation with stakeholders.

Federal EPSDT law also calls for dental, vision and hearing services according to state-specified periodicity schedules. This is meant to ensure that any hearing and vision problems are identified and treated early in a child's life. It also serves to ensure that children receive the oral health care they need to maintain dental health, including referral to a dentist.

As mentioned in the introduction, there is evidence that state performance in this area improved between 2007 and 2008. However, the 2008 data continues to show room for improvement, especially in participation (the measure of whether individuals who should have been screened during the fiscal year did, in fact, receive at least one screen). The major strategy states used to increase the number of children screened in accordance with the periodicity schedule was outreach to inform families of the importance of EPSDT screenings and other preventive care. They also relied heavily on partnerships with other agencies and organizations with shared goals. These are discussed in more detail later in this report, as are other strategies states have used to improve in this area, including:

- Changing coverage policies to facilitate access to preventive dental services such as authorizing payment to primary care providers for applying fluoride varnish, and
- Providing incentives for families to obtain screenings and for providers to increase the number of screens they deliver.

Provide Children with Access to Medically Necessary Diagnostic and Treatment Services

Preventive services and EPSDT screens support children's healthy development as well as early identification of any conditions requiring further assessment or treatment. However, identifying a need does

little good without access to follow-up care for the condition. As previously discussed, federal EPSDT law creates a broad package of benefits for children by explicitly requiring Medicaid agencies to cover all other services authorized by federal Medicaid law, including services the agency has chosen not to cover for adults.[9] In addition federal law requires agencies to cover services needed "to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services."[10] This provision, in effect, establishes a pediatric medical necessity standard in Medicaid that is broader than most commercial standards or those applied to adults covered by Medicaid.

States face two major challenges in ensuring access to medically necessary diagnostic and treatment services. First, there may not be an adequate supplies of providers, including dentists, to meet identified needs for assessment and treatment. Second, primary care providers and families may not know how to access these providers. This may be especially true of those services that are not part of the traditional health system, such as dental services, early intervention programs or mental health services. A related challenge is ensuring that the referral loop is closed—that referrals not only result in access to follow-up care but that information about diagnostic findings and any treatment provided are returned to the primary care provider. This information is critical for effective primary care and to increase primary care providers' confidence that children are able to access needed services (an important factor in encouraging providers to continue to make referrals).

Medicaid agencies are responsible for obtaining value for their money and remaining within budget. Thus, they face a fourth challenge in this area: not only to ensure that children access needed services, but that the services children access are medically necessary. EPSDT's comprehensive coverage adds complexity to this challenge since Medicaid agencies sometimes need to make case-by-case decisions about the medical necessity of expensive services that few need. Policymakers often cite the potential cost of these treatments as a concern. However, researchers have been unable to quantify the cost of this service due to the wide variability among states in the scope of Medicaid services covered for other populations.[11]

States have developed multiple strategies to meet these challenges. They have funded care coordination services to help providers and families access follow-up services, established special processes for accessing infrequently needed services, and in some cases, allowed specialty providers to serve as primary care providers. Partnering with other organizations and agencies, especially provider organizations such as the American Academy of Pediatrics (AAP), has also been important to achieving this goal.

Ensure Quality

The final goal for EPSDT programs is to ensure the quality of services delivered to children. Provision of EPSDT screening services that do not include all components or that are of poor quality could result in missed opportunities to identify children's needs or support their continued healthy development. Access to poor quality diagnosis or treatment services could result in misidentification of treatment needs, or ineffective (or inappropriate) treatment. Lack of effective linkages and feedback loops among the family, primary care provider and other providers or programs could prevent children from accessing needed care they qualify for and make it more difficult for primary care providers to serve as a true medical home for the child. States face challenges in each of these areas—ensuring that all components of a screen are provided, ensuring that all services are of preventive, diagnostic and treatment services are of adequate quality, and that care is coordinated.

States use several of the strategies discussed in the next section to ensure quality. They support providers in improving their practices, align policies with professional standards of care, conduct quality improve-

ment initiatives to measure and reward good performance, and implement care coordination strategies. Once again, partnerships with other organizations have been important to achieving this goal. Medicaid agencies have found provider and consumer organizations, as well as individual providers and family representatives, to be particularly valuable, as their participation helps ensure that the Medicaid agency's efforts are grounded in real world experience, address issues of importance to beneficiaries, and obtain provider buy-in.

State Strategies

The individual efforts states use to meet the three improvement goals can be grouped into eight strategies, which are presented here. Each of these strategies is intended to produce progress toward meeting more than one of the goals. And, almost all states combine strategies so that they can reinforce each other.

1. Partnering with others
2. Integrating EPSDT into other initiatives
3. Helping primary care providers implement EPSDT
4. Helping families secure EPSDT screening services and other preventive care
5. Supporting care coordination
6. Managing access to services not otherwise covered by the state Medicaid program
7. Aligning EPSDT policies with professional standards
8. Using data to make the case for change and reward improvement

Partnering With Others

Agencies and organizations other than Medicaid agencies are also interested in increasing screening rates because it helps them meet their own goals. For example, improving child health may be part of their mission (e.g., advocates and maternal and child health agencies) or they may be contractually obligated to achieve a specified level of performance (e.g., Medicaid-contracted MCOs).

Others that have partnered with Medicaid agencies include provider associations, state early education agencies, and community-based agencies. Federal agencies are also important partners; in addition to the obvious role CMS plays in the delivery of EPSDT, the Health Resources and Services Administration (HRSA) has supported multiple initiatives that are either dedicated to improving the delivery of EPSDT services (e.g., state workshops) or include such improvement among its aims (e.g., the Early Childhood Comprehensive System [ECCS)]).[13]

These agencies and organizations can contribute expertise, experience, and resources to achieving shared goals. For example, consumer organizations have worked to inform families about EPSDT and providers' professional organizations (e.g., AAP) have informed their members about changes to EPSDT policy and provided training to their members (or a venue for Medicaid to conduct training). The nature of these partnerships varies widely. Some are formalized by written agreements while others are more informal. Some are convened by the Medicaid agency while others are convened by another agency. State Medicaid agencies rely on these partnerships to plan and carry out activities intended to achieve all three of the goals discussed in the previous section. Three partnerships illustrate this variety.

Iowa Medicaid established a formal agreement with the state's public health agency to (1) assure cooperation between state agencies, (2) administer informing, care coordination, and enhanced prenatal services through local Title V agencies, (3) monitor quality, and (4) facilitate outreach through a toll free number, the Healthy Families Line. This partnership enables Iowa to consistently achieve an EPSDT participation rate of 80 percent.[14] Additionally, through a contract with Iowa Medicaid, the Iowa Department of Public Health

pays for EPSDT services provided by local Title V Maternal and Child Health agencies. These services include child health services (informing and care coordination) and maternal health services (presumptive eligibility outreach and care coordination).

Additionally, Iowa has created several valuable resources for families and providers including:

- The Iowa EPSDT Care for Kids Provider Resource Web Site designed to help providers promote the healthy development of children;[15]
- A toll free family help line connecting families to community resources; and
- A network of county-based EPSDT coordinators providing care coordination services to ensure families receive needed services

In **Arkansas**, ECCS project staff regularly hold meeting with leaders from Medicaid, Maternal and Child Health, Children with Special Health Care Needs, Part C Early Intervention, Mental Health, and other agencies to discuss ways that EPSDT can be used to assure health care access, medical homes, mental health, and healthy development for young children in Arkansas. The state has created a System of Care (SOC) Plan to improve integration across agencies and initiatives serving young children and their families. Specifically, a Medical Homes Work Group established by Department of Human Services and chaired by the Medical Director of Health Policy, in collaboration with the AR Early Childhood Comprehensive Systems (ECCS) Partnership Council, is working to develop medical homes for young children, foster children and the general Medicaid EPSDT population.[16]

Finally, in 2007 HRSA funded **State Leadership Workshops on Improving EPSDT and Title V Coordination**. Conducted in fourteen jurisdictions — Alaska, Arkansas, Colorado, Illinois, Iowa, Maine, Michigan, Ohio, Nevada, Puerto Rico, Tennessee, Virginia, Washington State, and Wyoming, these State Leadership Workshops were specifically tailored to foster successful coordination between State MCH and Medicaid agencies to improve the EPSDT program by increasing the number of eligible children receiving screening, diagnosis, and necessary treatment services.

These workshops included a mapping exercise in which participants identified how community and provider systems interface, including who has accountability for care coordination and case management and what funds are being used to finance these supports. These workshops have produced ongoing partnerships and policy improvements within the individual states—and the mapping exercise is being developed into one that can be used by other states as a discussion guide and approach to child health systems mapping. This tool was vetted during the annual AMCHP conference, piloted in Vermont and Colorado, and will be available on the HRSA website in late Febrary 2010.

Integrating EPSDT into Other Initiatives

Similar to the opportunities created to improve EPSDT by partnering with other agencies and organizations are the opportunities created by integrating EPSDT into state initiatives with congruent goals. Medicaid medical home initiatives offer especially good opportunities for integration. Like EPSDT, these initiatives envision (and seek to advance) effective, efficient primary care as the linchpin of the health care system. Studies support the benefits of the medical home model toward improving care quality and containing costs.[17]

Other recent work by NASHP has found that since 2007, more than half of the states have engaged in some activity to advance medical homes for Medicaid or CHIP program participants. This work also found that while many of these programs ultimately seek to improve the delivery of care to a broader popula-

tion, approximately half started with a subset of the Medicaid population—often children or children with special health care needs. In addition, NASHP found that many medical home initiatives are built on the primary care case management (PCCM) model that some Medicaid agencies have used since the 1980s.[18] Illinois and Colorado exemplify state approaches to integrating EPSDT into different types of medical home initiatives.

Illinois Health Connect is a PCCM program designed to advance medical homes. Providers receive a per member per month fee for PCCM activities that varies based on the member's eligibility category. (Eligibility category serves as a proxy for the complexity of enrollees' needs.) Participating providers are given information on necessary preventive services, including well child visits, structured developmental screening, as well as various education resources such as webinars, trainings, site visits and a help desk. Additionally, providers receive monthly patient rosters that identify enrollees who have missed a screening or other important service. This program also features a pay-for-performance program designed to, among other things, reward the provision of important primary care services. For example, physicians receive bonuses for meeting national 50th HEDIS percentile on a HEDIS-like measure developed to support structured developmental screening.[19]

> In typical PCCM programs, a Primary Care Provider (PCP) receives a monthly case management fee for each enrolled Medicaid beneficiary (enrollee) in addition to fee-for-service reimbursement for all services provided by the PCP to enrollees. In return, the PCP is responsible for providing primary care and managing access to other providers. The Medicaid agency will not pay for services provided to enrollees by a provider other than the PCP without the approval of the PCP.

Colorado's Department of Health Care Policy and Financing, which administers the Medicaid and SCHIP programs, works with the Department of Public Health and Environment to provide all children served by Medicaid or SCHIP access to a medical home. They have built this initiative on the EPSDT program which, they believe, supports all the elements of a high-functioning medical home for children. As of March 2009, about 150,000 children were being seen by more than 300 physicians practicing as a certified medical home.[20]

- Instead of paying a per member per month administration fee to qualified medical homes Colorado pays an enhanced fee for well-child visits (EPSDT screenings) provided within a medical home.
- Colorado has redesigned its EPSDT administrative case management program so that 'medical home navigators' are situated throughout the state, offering client education and supporting provider practices.
- Colorado provides regular reports to medical home providers about their performance, including their performance in providing EPSDT screening services.

Early data from Colorado support the value of this approach. Colorado implemented its medical home pilots in early 2007 and the CMS 416 data shows that between 2006 and 2007 the total number of children eligible for EPSDT decreased, but a greater number of children were referred for both preventive dental services and corrective treatment. They also achieved increases in both the EPSDT participant and screening ratios.[21]

Helping Primary Care Providers Implement EPSDT

As previously discussed, due to EPSDT both the benefit package and medical necessity standards provided to children by Medicaid are broader than that provided to children by private coverage. As a result,

Medicaid agencies have found they need to inform primary care providers about EPSDT policies, including billing policies, how to access services that are not covered for other populations, and any support available to assist with care coordination or improving office practices. Many states conduct workshops for primary care providers, but some are implementing more innovative practices.

- The **Oklahoma** Health Care Authority has an EPSDT video on YouTube aimed at physicians, physician assistants, nurses and administrative staff.[22] This video details Oklahoma's periodicity schedule, the specific components of well child care and billing and reimbursement policies.
- **Arkansas** Medicaid uses their External Quality Review Organization (EQRO) to provide targeted in-office training based on provider performance.[23]

Medicaid agencies have found the AAP to be a valuable partner in these efforts. Several states have partnered with local AAP chapters to help providers understand EPSDT. For example, Illinois's AAP chapter informs its members about changes in EPSDT billing and coding policies. In the District of Columbia, an AAP representative provides on-site training to private pediatric/family medicine practices, including several community health centers and conducts in-office training on an as-needed basis.

The national AAP has also produced resources that EPSDT coordinators have used to help providers fulfill EPSDT requirements. In October 2007, the AAP updated and published the third edition of their *Bright Futures Guidelines for Health Supervision (Bright Futures)*.[24] The new guidelines include resources primary care providers can use to implement the guidelines. Several state Medicaid agencies report using these resources to help primary care providers implement EPSDT. Specifically,

- **Iowa** uses *Bright Futures* to update and benchmark its EPSDT health program provider manual. As an additional provider resource, a link to the *Bright Futures* webpage is included, as well as footnotes throughout the manual highlighting where additional information on anticipatory guidance can be found in the *Bright Futures* guidelines.
- **Oklahoma** uses *Bright Futures* family tip sheets as a resource for anticipatory guidance.

Helping Families Secure EPSDT Screening Services and Other Preventive Care

Families are a key player in obtaining care for their children. They have both a responsibility and desire to ensure that their children get services they need. However, not all parents are aware of the importance of well-child care or how to access it. Low-income parents may be faced with difficulties in accessing care—including limited transportation options, lack of child care, and limited ability to take time off from work—that impede their ability to take their children to doctor's visits, especially when the child is not sick. Therefore, state Medicaid agencies have implemented strategies to inform families about the benefit of preventive care, as well as how and when to access it and the support available to help families obtain the care. States also cite family demand for services as a driver of provider interest in delivering the service. Medicaid agencies are particularly interested in supporting families' access to EPSDT screenings and preventive dental care.

EPSDT Screenings

Three states, Utah, Virginia and Delaware, illustrate the diverse approaches states are taking to educating families about the importance and availability of EPSDT screenings and other preventive care.

Utah Medicaid works with its local departments of health to conduct targeted outreach to specific age groups. Using a series of letters, phone calls and follow up contacts, local health departments encourage

families with children 6, 12 and 18 months of age to visit their primary care provider for the appropriate well-child visit. Public health nurses, working closely with primary care provider offices, contact families to assist in scheduling the appropriate EPSDT screens and follow up with families after the visit.

Virginia Medicaid both engages in direct activity to promote access to preventive care and directs contracted MCOs to inform families.

- The Medicaid agency provides new Medicaid enrollees with an EPSDT brochure describing available services and how to access them as well as periodic mailings to all Medicaid enrolled families to encourage their participation in EPSDT. The agency's Managed Care Help Line staff also informs beneficiaries about EPSDT services and encourages families to contact their primary care physician or a Medicaid enrolled EPSDT provider to schedule screening appointments for their children.
- The agency's MCO contract defines MCO informing and outreach responsibilities to include, at a minimum, promotion of EPSDT for new enrollees, including urging them to contact their primary care provider to schedule an initial screening. The contract also requires a clear description of EPSDT services in the member handbook and ongoing member education services encouraging participation in these services.

Finally, similar to the way states are using AAP's *Bright Futures* to support providers, Virginia is using the family resource materials developed for *Bright Futures* to support families. Virginia lists the *Bright Futures* family resource materials as a health information resource in family mailings. This state has also used the age specific content of the anticipatory guidance sections of *Bright Futures* in each developmental age group to develop family mailings that discuss age appropriate health topics and give family advice in enrollee birthday notices, or birthday newsletters.

In Delaware, the Medicaid agency's two contracted Managed Care Organizations (MCOs) offer incentives to their members for preventive care visits. One plan offers reward cards for keeping certain preventive doctor visits, including well-child visits (EPSDT screenings).

Preventive dental services

Many states are finding innovative ways to improve access to preventive dental services. For example, three states now allow independently operating dental hygienists to provide cleanings in some circumstances (Colorado, Nevada, and Oklahoma). Nevada, for example, allows a dental hygienist to perform preventive check-ups without supervision as long as she/he has received oral or written authorization from the supervising dentist or in the case of dental hygienists, with a Public Health Endorsement. Hygienists receive authorization from the Board of Dental Examiners.

In addition, as of July 2009, nine states (Alabama, California, Connecticut, Massachusetts, Maryland, Minnesota, Nevada, Utah, and Washington) allow primary care providers to apply fluoride varnish. Fluoride varnish—sodium fluoride 'painted' onto the surface of the teeth—reduces the incidence of early childhood tooth decay. All of these states limit provision of fluoride varnish to ensure that it is applied only when effective. Alabama, for example, allows primary care providers who have taken specified training to apply up to six varnishings to a child age 6 months-35 months. In addition, Utah will pay an enhanced payment if the varnish is applied in conjunction with the EPSDT screen

Supporting Care Coordination

Effective care coordination is beneficial to both families and providers. For families, care coordination connects them to appropriate services. For providers, having access to the information about services families receive

outside their office enables them to more effectively care for their patients. Care coordination is especially difficult across systems. Care coordination is easier to ensure between primary care and other types of physician specialists than between primary care and mental health providers or early intervention programs. Some states are providing resources to primary care providers to support care coordination. Some provide additional funding to pay for staff employed by providers or provider networks (e.g., North Carolina), others provide primary care providers with access to care coordination systems the state has established (and pays for) outside the provider's office (e.g., Maine, and Oklahoma), and others are implementing Health Information Technology (HIT) initiatives designed to support coordinated care (e.g., Oregon).

North Carolina's PCCM program pays a per member per month administrative fee to both the primary care practice and a local network of providers. Specifically, 14 non-profit Community Care Networks receive $3 per member per month to support practices with care coordination. Each network uses this funding to, among other things, support a part-time medical director to oversee quality, meet with practices, and serve on a state-wide Clinical Directors Committee, a clinical coordinator to oversee network operations, and care managers to assist practices.[25]

Oklahoma Medicaid has a Care Management Department that employs Registered Nurses and Licensed Practical Nurses to assist in facilitating medical services for Medicaid clients with complex medical conditions, including children. The nurses will:

- help beneficiaries access care and services
- assist providers with coordination of discharge planning
- resolve issues and concerns with providers as related to medical care
- help get approvals for medicine and medical services
- provide patient education to identified groups
- aid with coordinating community support and social service systems
- locate physician-specialists, home health providers and rehabilitation facilities (for members under 21) [26]

Also, as previously described, Colorado and Iowa have established Medicaid-funded systems of care coordination that employ local care coordinators to support the delivery of coordinated care to children. These staff both conduct outreach to support families' access to primary care and support linkages with other community services and programs.

In Maine, when an EPSDT well-child screen visit results in a referral, a public health nurse receives a copy. This provides an opportunity for follow up—typically on an as-needed basis and has graduated from telephone to face-to-face support—to ensure that the family has support to complete the referral and that the health care provider gets information back.

Finally, Oregon's FamilyNet, an initiative designed to improve Oregon's low rate of child identification of physical, developmental and behavioral delays, links all public health databases (including WIC, lead, hearing, and oral screening, immunizations, vital events, and home visiting programs, and others). In this way, Oregon is working to reduce silos and link data around the child, follow the child across systems, provide one access point for providers, improve coordination and referrals, and evaluate program effectiveness.

Managing Access to Services Not Otherwise Covered by the State Medicaid Program

As previously discussed, federal EPSDT requirements, in effect, establish a children's benefit package and medical necessity standard in Medicaid that is broader than most commercial coverage or that is available to adults covered by state Medicaid programs. Managing access to the additional services is important because Medicaid agencies need to both cover the services children need and spend state dollars wisely. To do this states: (1) need to implement a process to enable children to obtain medically necessary services that are not otherwise covered by Medicaid and (2) educate providers and families about the extent of Medicaid coverage and how to obtain these services.

Most Medicaid agencies have prior authorization processes in place to manage utilization of a number of different services. Prior authorization is a process through which providers may request coverage of a specific service for a specific beneficiary. If the agency judges the service to be covered by Medicaid *and* medically necessary for the individual, the agency will approve the request and pay for the service. In order to make decisions, states need both sufficient information about the case in order to judge medical necessity *and* sufficient evidence about the effectiveness of the proposed treatment to judge whether it meets the medical necessity standard.

Most Medicaid agencies have decided to use prior authorization to also manage access to services covered under EPSDT that would not otherwise be covered by the Medicaid agency. Requests for a service that can be covered under federal Medicaid law that meet the EPSDT standard for treatment (needed to treat or ameliorate….) must be approved for payment. Many states have developed forms to help guide providers through the process and make sure that the provider submits sufficient information with the form to enable the agency to judge the request.

Some states, such as California and Kentucky, have explicitly created a separate category of services for these additional services. This approach creates a separate identity for these services that the states use to market the services to provider and families.

- **Kentucky**'s EPSDT Special Services Program allows coverage for items or services which are medically necessary and which are not covered elsewhere in Medicaid. Preventive, diagnostic, treatment, or rehabilitative services may all be covered under Special Services and all of these services require prior authorization.
- **California**'s EPSDT Supplemental Service (EPSDT-SS) specifies that these services include: private duty nursing services from a Registered Nurse or a Licensed Vocational Nurse, case management, pediatric day health care, and nutritional and mental health evaluations and services. All EPSDT-SS claims require prior authorization and are reviewed on a case-by-case basis.[27] In addition California's EPSDT coordinator reported that the program ensures that the professional reviewing the request has appropriate expertise. For example, requests for dental services are reviewed by a Department of Health Services Dental Consultant.

In addition, because federal law specifies that EPSDT coverage policies apply to conditions "discovered by the screening services," some states, such as Alabama, require a written EPSDT referral by a screening provider/primary care provider in order for a child to receive additional medically necessary health care. This approach also reinforces the primary care provider as the locus for coordinating care. However, such a requirement can also be an impediment to services for conditions identified by a provider other than the primary care provider. To alleviate this problem, Alabama's EPSDT referrals are valid for one year from the date of the EDSDT screening. Some other states, such as Colorado and Hawaii, do not require EPSDT screening prior to referral to specialized services. Hawaii reported that this policy is of particular benefit to children who are

chronically ill or have special needs as these children, who often see a specialist more often than a primary care provider, are more likely to need specialized services than other children and less likely to receive regular well child visits (EPSDT screening).

Aligning EPSDT Policies with Professional Standards

There are several reasons why aligning EPSDT policies with professional standards supports delivery of EPSDT services. Reducing, to the extent possible, the differences between EPSDT and private coverage can ease, and thus encourage, provider participation. Also, professional standards, such as those communicated by *Bright Futures*, are established by leaders in the provider community with consideration informed by scientific evidence. Aligning EPSDT policies with these standards enables Medicaid to take advantage of this work to ensure quality, enables providers and families to use resources developed to support these initiatives, eases partnerships with other organizations by creating similar goals. In particular, *Bright Futures* and appropriate use of common coding systems can provide leverage for states.

In October 2007, the AAP updated and published the 3rd edition of their *Bright Futures Guidelines for Health Supervision*.[28] These guidelines provide recommendations for the content of care for well-child visits from birth through age 21 and added three new well-child visits, at 30 months, 7 years, and 9 years. As of June 2009, 14 Medicaid agencies had changed their EPSDT periodicity schedules to incorporate one or more of these new visits.[29] At least two (Maine and New York) have changed their EPSDT policies to explicitly tie their expectations for the content and schedule of EPSDT screenings to the *Bright Futures* guidelines.

Another way states can align their policies with national standards is to align billing policies with national procedure and diagnosis coding standards. Using the same coding structure as other payers makes it easier for providers to accurately bill (and bill accurately) for services. In turn, the increased accuracy raises the value of claims data for performance measurement. According to Dr. Joel Bradley, General Pediatrician and Associate Clinical Professor of Pediatrics at Vanderbilt University, "the coding system is a key component of quality data tracking and the reimbursement for EPSDT services."[30]

Using Data to Make the Case for Change and Reward Improvement

State Medicaid agencies are using data to make the case for change and reward improvement. Even a small amount of meaningful data can make a powerful case for change—and even a small reward can incent change. Arkansas, Michigan, and Rhode Island illustrate these potential uses for data.

Arkansas implemented several Medicaid incentive programs connected to their Medical Home initiative designed to support improvement in provider performance, including one designed to reward EPSDT screening. This program, effective as of July 2008, was developed with input from the provider community. It allocates $1.4 million in annual bonuses to primary care providers who screen beneficiaries at a higher rate than the statewide average, both overall and in specified age categories. These bonuses are determined based on the ratio of actual screens compared to expected screens given the number of beneficiaries and the length of their enrollment.[31] Because Arkansas undertook other efforts to improve EPSDT performance during this time period, it is difficult to assess the effect of this change. However, the CMS 416 data show increases in both the EPSDT participant and screening ratios between 2007 and 2008.[32]

Michigan[33] used data to improve lead screening (a required component of an EPSDT screen). Michigan reports that this initiative resulted not only in increased screening[34] but also in improved linkages between primary care providers and other child and family health service providers. Michigan Medicaid worked with the Michigan Public Health Childhood Lead Poisoning Prevention Program to develop a lead testing database that could be used to identify children who had received a lead test and measure performance in this area. Both worked with

the Michigan Care Improvement Registry to create a link between the Registry (which was already used by providers and plans to support immunization) and the lead testing database. As a result, providers and plans can now access information about a child's lead testing status through that portal.

The Michigan Department of Community Health uses Medicaid Managed Care contracts with 14 health plans operating in 42 of 43 counties to deliver EPSDT services to Medicaid beneficiaries. These contracts delineate performance requirements and outline provisions for administration of EPSDT services, including lead testing. Michigan added several provisions designed to increase lead screening to these contracts based on measures showing poor performance in this area. Each contract includes a requirement to meet a performance benchmark of "at least 75 percent of continuously enrolled children at the age of 2 years old receive at least one blood lead test on or before their second birthday."[35] Compliance with this benchmark is measured using the data from the previously described database. Also, in 2005/2006, all contracted plans were required to conduct a performance improvement project on lead testing as a result of data showing poor performance in this area. Each health plan had two cycles to demonstrate improvement in lead testing or face sanctions. In addition to sanctions, Michigan offered a reward for improvement in this area. Plans with higher rates of blood lead testing (among other factors) are assigned a greater proportion of new enrollees who do not exercise their option to choose a plan. Michigan successfully reached their goal of lead testing 80 percent of continuously enrolled Medicaid eligibles in 2007.

A Performance Incentive Program in Rhode Island allows health plans to earn payments over and above their capitation as rewards/incentives for improving performance. For EPSDT, the minimum standards are: a) 85 percent of members under age two are immunized according to schedule, b) members between [ages] 6 and 20 are provided EPSDT age-appropriate screenings, and c) new members under age 18 receive a first visits with a [primary care provider] PCP within 90 days of enrollment.[36]

Conclusion

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is Medicaid's comprehensive and preventive child health program. EPSDT includes periodic well-child visits, diagnosis, and treatment services. It also includes the support families need to access these services. EPSDT's coverage is broad—Medicaid agencies must cover all services authorized by federal Medicaid law and all services needed to correct or ameliorate conditions discovered by an EPSDT screen. This broad coverage, combined with the large number of children covered by Medicaid, makes it critical that Medicaid agencies provide efficient, effective access to EPSDT services. They are responsible for ensuring that children get the services they need to reach their potential, as well as, obtaining value for the money they spend and remaining within budget.

As reported here, NASHP, through its work with EPSDT staff identified three state goals for EPSDT improvements:

1. Providing all children with scheduled EPSDT screenings (well-child visits) and other preventive care;
2. Providing all children with access to medically necessary diagnostic and treatment services;
3. Ensuring the quality of all EPSDT services provided to children.

There is some evidence that states are making progress toward achieving these goals. For example, between 2007 and 2008 both the national participant and screening ratios increased—as did the rates in some of the states highlighted in this report. However, there is clearly still room for improvement. In 2008, although the national screening ratio achieved the federal benchmark of 80 percent, the participant ratio fell short of that mark.

Finally, NASHP discovered important lessons about how states are using the eight strategies identified in this report to achieve their goals for program improvement.

1. Medicaid agencies do not rely on a single strategy to achieve their goals for program improvement. Rather they craft a combination of strategies with input from potential partners and based on state or local level information about program performance and available resources for improvement.
2. Medicaid agencies can maximize the effect of their efforts by partnering with other agencies with similar goals and, to the extent possible, aligning EPSDT policies with those of other programs or organizations.
3. Medicaid agencies can support both primary care providers and families in fulfilling their responsibilities in ensuring that children receive the preventive, primary and treatment services they need. Both need support to understand the potential range of services available through EPSDT, how to access those services, and the limit of that coverage. Both also benefit from support tailored to their roles. For example, families benefit from access to translation and transportation services; primary care providers benefit from support to help them integrate EPSDT requirements into their practices and provide guidance to families. Both benefit from resources to support care coordination.
4. Medicaid agencies use data to make the case for change and reward improvement. They measure performance to document the need for change and whether changes are producing improvements. They use the quality improvement infrastructure they are required to establish as part of their managed care programs (e.g., performance improvement projects) as effective levers for improving the delivery of EPSDT services. And, they have found ways to use both penalties and incentives to secure improvements.

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